ALO--WWID-WIPP-2000-0003 Final Report

Occurrence Report

Waste Isolation Pilot Plant

(Name of Facility)

Nuclear Waste Operations/Disposal

(Facility Function)

Carlsbad Area Office Westinghouse Waste Isolation Div.

(Laboratory, Site, or Organization)

Name: XXXXX
Title: ASSIST MGR **Telephone No.:** XXXXX

(Facility Manager/Designee)

Name: XXXXX
Title: ASSIST MGR **Telephone No.:** XXXXX

(Originator/Transmitter)

Name: **Date:**

(Authorized Classifier (AC))

1. Occurrence Report Number: ALO--WWID-WIPP-2000-0003

Improper entry into Radioactive Materials Area

2. Report Type and Date: Final

	Date	Time
Notification:	06/29/2000	12:26 (MTZ)
Initial Update:	07/14/2000	13:16 (MTZ)
Latest Update:	07/14/2000	13:16 (MTZ)
Final:	09/05/2000	05:41 (MTZ)

3. Occurrence Category: Off-Normal

4. Number of Occurrences: 1 **Original OR:**

5. Division or Project: WID/WIPP

6. Secretarial Office: EM - Environmental Management

7. System, Bldg., or Equipment: 411- Waste Handling Building - Radioactive Materials Area

8. UCNI?: No

9. Plant Area: CH Bay

10. Date and Time Discovered: 06/28/2000 09:17 (MTZ)

11. Date and Time Categorized: 06/28/2000 11:10 (MTZ)

12. DOE Notification:

13. Other Notifications:

14. Subject or Title of Occurrence:

Improper entry into Radioactive Materials Area

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15. Nature of Occurrence:

10) Cross-Category Items

C. Potential Concerns/Issues

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16. Description of Occurrence:

On June 28, 2000 a maintenance person entered a posted Radiological Materials Area (RMA) without the appropriate dosimetry. The person did have the required Thermoluminescent Dosimeter and did not check out the Electronic Personal Dosimeter. The individual believed he was entering a Controlled Area and not an RMA. He was expecting a yellow and magenta rope separating the Controlled Area and RMA. In the current configuration, the entry doors are the barriers to the RMA and a rope was not needed. The doors are posted with the requirements for entry. Once the individual entered and did not encounter the rope he exited the area and notified the Radiological Control Personnel and the Central Monitoring Room.

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17. Operating Conditions of Facility at Time of Occurrence:

Waste Stored in the Underground and the CH Bay

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18. Activity Category:

03 - Normal Operations

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19. Immediate Actions Taken and Results:

The individual self reported the event and notified Radiological Control Personnel immediately. The individual's TLD was removed for dose assessment and will be returned once further investigations are complete.

20. Direct Cause:

3) Personnel Error

A. Inattention to Detail

21. Contributing Cause(s):

22. Root Cause:

3) Personnel Error

A. Inattention to Detail

23. Description of Cause:

After review of the event and interview of the maintenance person by the Responsible Manager it was determined that the root cause of the event was inattention to detail. The person read the sign and entered the area without the EPD. The maintenance person aknowledged that he understood the sign The entry door is properly posted with the requirements and the Radiation Work Permit also states the requirements for entry. The direct cause was entry into the RMA by going through a physical posted barrier (door), inattention to detail.

24. Evaluation (by Facility Manager/Designee):

Review of the event and investigation were completed on June 30, 2000. The event was due to personnel inattention to detail. The constant reminder of radiological postings is being emphasized to the appropriate work groups. There are no other impacts to the plant, systems, or programs.

25. Is Further Evaluation Required?: No

26. Corrective Actions

(* = Date added/revised since final report was approved.)

1. A remedial action plan was developed (containing training and reviews with the Radiological Manager and Cognizant Manager) and will be completed by the individual prior to reinstatement as a radiological worker.

Target Completion Date: 07/31/2000	**Completion Date:** 07/06/2000

2. The Maintenance Manager will address this issue with the Maintenanace Department to reinforce the need to follow posted radiological requirements through toolbox meetings.

Target Completion Date: 07/31/2000	**Completion Date:** 07/27/2000

27. Impact on Environment, Safety and Health:

None.

28. Programmatic Impact:

None.

29. Impact on Codes and Standards:

Not Applicable.

30. Lessons Learned:

Emphasis needs to be placed on attention to detail during operations on a regular basis.

31. Similar Occurrence Report Numbers:

1. None

32. User-defined Field #1:

33. User-defined Field #2:

34. DOE Facility Representative Input:

No FR comments.
Entered by: XXXXX Date: 09/05/2000

35. DOE Program Manager Input:

36. Approvals:

Approved by: **XXXXX**, Facility Manager/Designee
Date: 07/14/2000
Telephone No.: XXXXX

Approved by: XXXXX, Facility Representative/Designee
Date: 09/05/2000
Telephone No.: XXXXX

Approved by: Approval delegated to FR
Date: 09/05/2000
Telephone No.: **XXXXX**